CMS Questions on TennCare Redesign
April 24, 2002

1. What are the floors and ceilings of eligibility levels for the 3-program structure? What are the eligibility levels across the different age categories? Is the ceiling for Medicaid where the floor for Standard begins?

We are assuming that the "floors and ceilings" referred to are financial and age eligibility requirements. As you are probably aware, each Medicaid category has its own financial and age eligibility requirements—there is not one set of "floors and ceilings" across Medicaid categories or across age groupings within Medicaid categories.

For the TennCare Standard program, there are no floors in financial eligibility requirements. The financial ceilings vary by eligibility category. There are some variations in age requirements. As indicated in the table we sent with our amendment requests, these are as follows:

Group C: Tennessee residents who are uninsured, who do not have access to group health insurance, and who have incomes below 250 percent of poverty.

Financial floor: *None*
Financial ceiling: *250 percent of poverty, although this could be lower and could be different for children and adults, depending upon the funding level appropriated by the General Assembly and the availability of funds within the federal budget neutrality cap.*
Age floor: *None*
Age ceiling: *None*

Group D: Tennessee residents at any income level who are uninsured and who are determined to be "medically eligible" by a state contracted medical underwriter.

Financial floor: *None*
Financial ceiling: *None during an open enrollment period. 100% of poverty at all other times.*
Age floor: *None*
Age ceiling: *None*

Group E: Tennessee residents at any income level who were enrolled in TennCare as of December 31, 2001, with Medicare but not Medicaid coverage, and who continue to meet the criteria for "Uninsurable" status in place at that time.

Financial floor: *None*
Financial ceiling: *None*
Age floor: *None*
Age ceiling: *None*

Group F: Tennessee residents who were enrolled as Uninsured children in TennCare as of December 31, 2001, even if they had access to insurance, because their family incomes were below 200% poverty and who continue to meet the criteria of being under the age of 19 and with family incomes below 200% poverty.

Financial floor: *None*
Financial ceiling: *200% of poverty*
Age floor: *6 months (would have to have been enrolled as of December 31, 2001)*
Age ceiling: *19 years*

TennCare Assist, as we indicated in the request for modifications, will have a financial ceiling of 250% of poverty, although this could be lower depending upon the funding level appropriated by the General Assembly and the availability of funds within the federal budget neutrality cap. It could also be set at different amounts for adults and children. There are no age floors or ceilings for TennCare Assist.

2. How many individuals do you propose to cover under the new program? Under each program? How many new individuals?

The program design at full flexibility and FPLs at the maximum range is estimated to cover an average of 1,440,400 persons in FY 2003. As previously provided, current estimates for the program at full flexibility break down as follows:

Medicaid—1,049,500
Uninsured—246,930
Medically Eligible—97,970
Waiver Duals—46,000

These estimates include an open enrollment period that is projected to result in an average annual increase of 40,000 enrollees.

3. The proposal says that funding is not guaranteed and therefore income eligibility levels could be decreased, which results in different eligibility criteria for adults vs. children, Medicaid vs. expansion, current enrollees vs. new enrollees? Will you create a waiting list? If so, how will you prioritize who is eligible first?

The following groups are considered our "baseline" groups for TennCare enrollment:

a. Medicaid eligibles. Medicaid eligibles can enroll at any time. The waiver amendment proposal even allows a new way of protecting effective dates for Medicaid eligibles who need to apply at times when DHS offices are not open.

b. Medical eligibles under 100% of poverty. These persons will be able to enroll at any time.

c. Persons losing Medicaid eligibility who do not have access to insurance and whose incomes are below certain levels. These income levels will be set by legislative appropriations and could change, depending upon the availability of funding. Persons losing Medicaid eligibility who do not have access to insurance but whose incomes are greater than the maximum may be eligible for TennCare in the "Medically Eligible" category, or they could be eligible as uninsureds during a later open enrollment period if a higher income threshold is provided.

d. Certain currently eligible demonstration enrollees—see Groups E and F in waiver amendment proposal.

With respect to managing enrollment of members of the demonstration population who are not in one of the above groups, we do not anticipate maintaining a waiting list. Rather, we will analyze our current enrollment and the availability of funds at regular intervals to determine if and when we can add new enrollees and what income level criteria we will use. We will decide whether to use different income criteria for children and adults.

When these decisions are made, we will announce them along with the timing of the next open enrollment period, and we will enroll all who apply and who meet those criteria during that open enrollment period. Once the open enrollment period is closed, there will be no additional TennCare enrollments except in the first three categories above. (Persons in the fourth category are already enrolled.) People who applied during the open enrollment period and who were determined to be over-income will have to wait until the next open enrollment period to find out if the income criteria might possibly be higher. Of course, people always have the

option of applying for Medicaid or applying as medical eligibles, if their incomes are below 100% of poverty.

We have included in our waiver amendment proposal an option to lower the income criteria for current waiver eligibles, which could mean that demonstration members whose income exceeds the new criteria and who do not fit the criteria for the first three options above would be disenrolled from the program. It is important for the state to have these tools to manage enrollment within legislative appropriations and the availability of funds within the federal budget neutrality cap.

4. Define the state's meaning for "continuous enrollment," "open enrollment," and "prospective enrollment." Do these terms differ in each of the three program structures? What can an applicant vs. an enrollee do in an open enrollment period—change plans, change docs?

Under our new plan, all three of the above terms pertain to applicants and not to enrollees. All three have the same meaning for TennCare Medicaid, TennCare Standard, and TennCare Assist.

"Continuous enrollment" means that enrollment is open at any time. Persons who meet the criteria for one of the categories for which continuous enrollment is possible (Medicaid eligibles, medical eligibles with incomes below 100% of poverty, uninsured persons losing Medicaid eligibility whose incomes are within established ranges) can enroll when they file completed applications, assuming that their applications are approved.

"Open enrollment" refers to a designated period of time during which uninsured persons whose income is within certain limits can enroll, as well as medical eligibles whose incomes are above 100% of poverty. We anticipate holding two open enrollment periods each year. The enrollment criteria will be announced ahead of time, and all who apply and who meet the criteria will be allowed to enroll.

"Prospective enrollment" refers to the period of time after the end of the open enrollment period before the individual is actually enrolled in the program. During this time, the individual's information with respect to his access to insurance, his income, etc., will be verified, and any applicable premiums will be collected. The individual will be considered to be "prospectively enrolled" once these matters have been satisfied. The actual date of enrollment is anticipated to be either July 1 or January 1 following the end of the open enrollment period.

"Open enrollment" will be used only to refer to the period when applications for TennCare are accepted from non-Medicaid eligibles who cannot enroll during continuous enrollment periods. We do not intend to use the open enrollment period as a time for current enrollees to change MCOs. Instead of employing an annual change period, it is our hope ultimately to allow enrollees to have the opportunity to change plans when they come into DHS to have their eligibility re-determined every year or so. This way, plan changes will be staggered throughout the year, rather than occurring all at once.

The open enrollment period has never been used as an opportunity to change doctors. That process occurs through the MCOs. According to the state's contract with the MCOs, they can establish policies and procedures to enable enrollees reasonable opportunities to change primary care providers. These policies and procedures may not specify a length of time greater than 12 months between changes under normal circumstances. If a time restriction for changes is imposed, the MCO must include provisions for more frequent changes with good cause.

5. **What are the differences in pharmacy benefits (in terms of services, benefits, costs, limitations, exclusions) between the state's TennCare Select plan and the state's pharmacy program?**

The state's TennCare Select program, like all the other MCOs in the program, will manage the pharmacy benefits of its members except in two instances: behavioral health pharmaceuticals, and pharmacy services for dual eligible Medicare/Medicaid individuals. These two categories of the pharmacy program are managed by the state's pharmacy program. We have asked for the ability to require that all Medicare/Medicaid dual eligibles be enrolled in TennCare Select.

6. **Benefits for Medicaid: The 125-day home health limit per enrollee/per year—define "visit"—is it the number of days an aide is in the home or per hour? If so, a person could run through their 125 visits very quickly. What is the average number of home health visits for current TennCare beneficiaries? Limits on home health services for poverty-level people and eliminating sitter services, convalescent care, and private duty nursing care could drive more people into institutions, which is inconsistent with the Administration's New Freedom Initiative and Olmstead. Does TennCare have other 1915(c) demos in place that might pick up the care needs for folks who are being affected by this cut. What does the state mean by "convalescent care"?**

"Home health" means the following services when provided by a licensed home health agency under a required physician's order: (1) part-time or intermittent nursing; (2) home health aide; (3) medical supplies, equipment, and appliances suitable for use in the home; and (4) physical therapy, occupational therapy, speech pathology or audiology. A home health visit is not defined on an hourly basis. In our May 31, 2000, request for waiver modifications, we indicated that only 160 adults, or .02% of the adult population, used more than 60 home health visits a year. This number was calculated using data from 1998.

Convalescent care and sitter services are not Medicaid services. These were added to the TennCare benefit package at the time TennCare was implemented to make sure that TennCare contained all the benefits available through the State Employees Insurance Program. Private duty nursing services are Medicaid services, but were not covered by Medicaid prior to TennCare except for children under EPSDT. The remainder of the TennCare benefit package—unlimited physician services, unlimited clinic visits, unlimited outpatient hospital visits, unlimited hospitalizations, unlimited pharmacy services—is quite comprehensive and should be effective in minimizing the need for inappropriate institutionalization.

The state has four 1915(c) waiver programs, as well as a PACE waiver, and has applied to CMS for approval to implement a fifth 1915(c) program.

The definition of "convalescent care" that we have used comes from the State Employees Plan. It is as follows: up to 100 days during any calendar year for confinement in convalescent facilities (room, board, and general nursing care), provided that the confinement is recommended by a physician, the enrollee is under the continuous care of a physician, and the confinement is required for care other than custodial care.

7. Administration—Who administers TC Standard? Please describe.

TennCare Standard, like TennCare Medicaid and TennCare Assist, will be administered by the state's TennCare agency. Benefits will be delivered through the MCOs and BHOs participating in the TennCare program. Families could have some members in TennCare Medicaid and some members in TennCare Standard, but they will have only one MCO and one BHO, unless someone in the family is enrolled in TennCare Select. The managed care entities will be responsible for administering both benefit packages.

8. On page 22, define "basic HMO package." How does it compare to Medicaid level benefits provided in this waiver?

According to Tennessee law, HMOs must offer "basic health care services." These are defined as follows: “all those health services which a defined population might reasonably require in order to be in good health, including as a minimum, but not limited to, emergency care, inpatient hospital and physician care, ambulatory physician care and outpatient preventative medical services.” The Medicaid level benefits provided in the waiver are considerably more comprehensive than the basic health care services which are required to be offered under an HMO. The Medicaid benefit package includes hospice care, home health care, pharmacy services, durable medical equipment, medical supplies, emergency and non-emergency ambulance transportation, renal dialysis services, EPSDT services, therapy services, etc.

9. Attach A—Some of the benefits refer to TennCare Handbook. Can we have it?

This handbook will be forwarded to CMS at the time it is completed.

10. Attach C—Are these premium costs the same for adults and children?

Premiums are for individuals and families. An individual could be an adult or a child—the premium for an individual is the same.

11. What is the premium structure for TC Standard pharmacy benefit only?

These figures are still being analyzed.

Additional Questions

1. According to page 9 of the application, Eligibility Group A is made up of residents who meet current eligibility requirements. Please describe Tennessee's current eligibility requirements, including a list of the covered populations and their income levels.

Information on current TennCare/Medicaid eligibility requirements is contained in the Tennessee State Plan for Medical Assistance, which has been approved by CMS. Major groups identified in the State Plan, along with their income levels if other than federally established income levels, are as follows:

- Qualified pregnant women and infants to age 1, with a maximum income of 185% of poverty;
- Qualified children from age 1 to age 6, with a maximum income of 133% of poverty;
- Qualified children from age 6 to age 19 (birthdays must be after September 30, 1983), with a maximum income of 100% of poverty;
- Presumptively eligible women, with a maximum income of 185% of poverty;
- AFDC (now TANF) recipients (net income limit of $830 for a family of 3, which is about 68% of poverty);
- SSI eligibles;
- Medically needy individuals who meet state income thresholds starting at $317 per month for a family of 3, which is about 26% of poverty (these persons get a full year of TennCare/Medicaid coverage);
- Qualified Medicare Beneficiaries (Medicare cost-sharing only unless individual is eligible for Medicaid);
- Qualified disabled and working individuals (Medicare Part A premiums only);
- Special low-income Medicare beneficiaries (Medicare Part B premiums only);
- Individuals requiring nursing facility care or care in an intermediate care facility for the mentally retarded, with maximum incomes set at 300% of the SSI benefit rate;
- Individuals who would be eligible for Medicaid if they were in a nursing facility or an intermediate care facility for the mentally retarded, who, but for the provision of home and community based services, would require institutionalization, with maximum incomes set at 300% of the SSI benefit rate;
- Children in special living arrangements (e.g., state custody), with maximum incomes at the foster care board rate value ($418 for a child from birth to age 2; $425 for ages 3-5, etc.);
- Individuals under age 21 in adoptions subsidized in full or part by a public agency, with maximum incomes at the amounts shown above;

- Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level, which is 300% of the SSI benefit rate.

2. The proposal states that Groups C through F are demonstration populations. Please provide the following information:

- **Do any populations who qualify for Groups C through F potentially qualify for Group A? If yes, please describe.**
  Persons in Groups C through F who might potentially qualify for Group A will be directed to apply for Medicaid. It is our intent that all persons who might be Medicaid-eligible will be enrolled in that category, regardless of whether or not they are also eligible for other categories. Individuals enrolled in Groups C through F who have a change in their circumstances, meaning that they might become eligible for Medicaid, are asked to report those changes to DHS so that they can be reviewed for Medicaid eligibility, if appropriate.

- **Please provide <u>minimum</u> income eligibility levels for Groups C, D, E, F, and G. For example, can individuals with incomes below 100% FPL qualify for Group C?**
  There are no minimum income eligibility levels for any of the TennCare eligibility categories. Individuals with incomes below 100% of poverty can qualify for Group C if they are uninsured and do not have access to group health insurance. Unless they are able to meet medical eligibility criteria, the times when they can enroll in TennCare are limited, however. We anticipate having two open enrollment periods each year for uninsured people and medical eligibles with higher income levels, subject to legislative appropriations and availability of funding under the federal budget neutrality cap.

3. We are currently trying to assess how the state plans to reduce the benefit package for mandatory eligibles (whom we understand to be Group A). We note that the proposal states that the following services will be eliminated for adults: sitter services, adult cataract glasses, convalescent care, and private duty nursing services. Which of these services, if any, are part of the state's mandatory benefit package? Will the reduced benefit package apply to all Medicaid-eligible adults or certain sub-populations? Does the state expect that the proposed reductions will have an adverse effect on this population?

First of all, we want to clarify that Group A consists of the Medicaid categories currently covered in our State Plan. Some of these are

mandatory Medicaid eligibility groups, but some of them (e.g., the Medically Needy) are optional Medicaid eligibility groups.

None of the services which are proposed to be eliminated for adults are included in the state's current Medicaid State Plan. All of these services were added to the TennCare benefit package to assure that TennCare offered, as a minimum, everything offered by the State Employees Plan. (TennCare actually offers quite a bit more than the State Employees Plan.) The reduced benefit package will be applicable to all Medicaid adults. Our analysis of the impact of these reductions was included in our May 31, 2000, correspondence to CMS requesting program benefit changes.

Concerning the changes to Medicaid home health—limiting home health benefits to 125 visits per year. We are aware that Tennessee developed an application for a new HCBS waiver to provide personal care and other services for individuals who have a nursing facility level of care. The application is pending with CMS, however, it has not been approved and it has not been funded by the State Legislature. It has been suggested that very few enrollees will be affected by this limit, and the state does not expect significant savings by imposing these limits. Would the state consider removing the home health visits limitation?

We want to be clear that we are proposing a 125-visit limit on home health services for *adult* Medicaid enrollees, not all Medicaid enrollees. This limit is over twice as high as the 60-visit limit approved for the Medicaid program prior to TennCare. Also, the funding for our new long-term care waiver has been approved and is included in the state's budget.

We believe the 125-visit limit on home health services for adult Medicaid enrollees is a reasonable one. We expect that very few enrollees will reach this limit, and having it in place underscores TennCare's position that long-term care is outside the scope of the managed care portion of TennCare. Home health care is a vehicle for delivering health care, and there are other service delivery vehicles available under TennCare even if the home health benefit is exhausted. Physician visits, outpatient hospital visits, clinic services, etc., remain unlimited for Medicaid adults.

Impact on children—Has the state assessed the impact on children above 100% of poverty who might be at risk for institutionalization due to the change in benefits?

We do not believe that the changes in benefits pose a significant increase to the risk of inappropriate institutionalization of children for long-term care (LTC). The changes in benefits affect primarily the demonstration

population, and LTC institutional services have never been covered for the demonstration population. Only Medicaid eligibles have access to these services. Children who might need LTC institutionalization have several Medicaid categories which might be available to them, depending upon their circumstances.

4. Transition to new coverage groups—Has the state developed any contingencies for individuals with disabilities who face a loss or reduction of coverage or benefits who may be placed at risk of inappropriate institutionalization?

As stated previously, we do not believe that the benefit reductions pose a significant increase in the risk of inappropriate institutionalization for long-term care (LTC), since the benefits remaining are quite comprehensive. Also as stated before, LTC institutional services have never been covered for the demonstration population under TennCare.

Currently covered demonstration eligibles who will lose benefits under the new plan fall into two groups:

- Persons who are not Medicaid-eligible and who have access to group insurance (other than those in Groups E and F), and
- Persons who are not Medicaid-eligible, who do not have access to group insurance, who do not qualify for medical eligibility status under the new program, and whose incomes are above the threshold set by the state for the uninsured population.

There are two Medicaid categories available specifically for persons with disabilities. One is the Medically Needy category, and the other is Supplemental Security Income (SSI).

5. Will individuals classified as hypothetical "Medicaid eligibles" for the purposes of budget neutrality receive corresponding TennCare Medicaid benefits? (For example, will uninsured children under 200% receive TennCare Medicaid or TennCare Standard?)

All current demonstration eligibles, including the hypothetical "Medicaid eligibles," will be assessed for Medicaid eligibility in accordance with the Tennessee State Plan and put into a Medicaid category if they qualify. At the time they become Medicaid eligibles, they will be eligible for TennCare Medicaid benefits. Uninsured children under 200% of poverty who are Medicaid eligible according to the State Plan will receive TennCare Medicaid benefits.

6. Will enrollment in the new system be based on a single point of entry model?

Yes. Almost all applicants other than SSI applicants will have their eligibility determined at the Department of Human Services. (Those applying for medical eligibility status will have the additional step of applying through the state's underwriter, but this will occur after they have gone to DHS.) The only exceptions to this policy are as follows:

- Children in state custody, whose eligibility is determined by Child Benefits Workers in the Department of Children's Services,
- Presumptively eligible pregnant women, whose Medicaid presumptive eligibility is determined by health care agencies operating under the Title V agreement, and
- Presumptively eligible uninsured women under age 65 who have been determined by the Centers for Disease Control to need treatment for breast or cervical cancer.

7. Enrollment periods—Please confirm the state's position on enrolling medically eligible persons below federal poverty levels on a continuing basis.

It is the state's intent to enroll medically eligible persons with incomes below the federal poverty level at any time these people qualify for the program.

8. Clarity concerning criteria for Group D in proposed waiver modification—Can the state please provide a copy of the criteria that will be used to determine medical eligibility?

The state has a draft of an underwriting tool that has been prepared for us by Milliman USA Consultants and Actuaries of Seattle, Washington. This tool is currently being reviewed by a number of experts and representatives of the insurance industry. At such time as the tool is finalized, we will send a copy of it to CMS.

9. Will the state set a maximum income level for persons who are uninsured/medically eligible?

We do not anticipate a maximum income level for medically eligible persons who enroll during open enrollment periods. There will be a maximum income level of 100% of poverty for medically eligible persons who wish to enroll during a time other than an open enrollment period.

There will also be a maximum income level for persons losing Medicaid who lack access to insurance. This income level will be established based on legislative appropriations.

10. Has the state considered implementing an enrollment cap?

It is not the state's intent to seek an enrollment cap at this time.

11. Loss of coverage: How many enrollees will lose coverage as a result of these changes?

The state does not have exact figures on how many enrollees will lose coverage as a result of these changes. There are a number of enrollees in the current demonstration population who might be Medicaid-eligible but who have not recently, or ever, applied. In addition, there are some enrollees in the "Uninsured" category who could be eligible under the medical eligibility category.

Given these caveats, we estimate that approximately 3500 enrollees with incomes above 250% of poverty may lose coverage under the proposal. The bulk of these are adults (2600), with the remainder being children (900). Some of these enrollees may qualify for medically eligible status. If the Legislature determines that an income level lower than 250% of poverty is appropriate for implementation this year, the number of enrollees who will no longer be eligible could be higher. Some enrollees currently enrolled as "Uninsurables" may not meet the medical eligibility criteria. However, they may qualify during open enrollment periods as an uninsured enrollee.

12. Premiums and copayments—Please clarify if emergency room copayments are required when the enrollee has a true emergency which does not require an inpatient admission (i.e., treatment of broken bones, suturing of wounds.)

The state has not made an effort to differentiate situations that are "true" emergencies from situations that are not "true" emergencies. We believe that we would be in violation of the "prudent layperson" standard in the Balanced Budget Act of 1997 if we attempted to do so.

Has the state considered placing caps on the aggregate annual amount that a family or individual would be required to pay in premiums and copays?

Yes. The state currently has an Out-of-Pocket Maximum for copays. This was not mentioned explicitly in the request for waiver modifications since it had already been approved. The current OOP maximums are as follows:

- 100%-200% of poverty $1,000 individual; $2,000 family
- 200% of poverty and above $2,000 individual; $4,000 family

13. What will the application fee be for TennCare Standard participants? (The proposal indicated a range of $25-$50.) How will the cost-sharing sliding scale be developed/implemented?

The application fee applies only to those applying for medical eligibility status and not to all TennCare Standard applicants. It is intended to be set at a level to offset some of the costs of using a medical underwriter. The fee will be a single amount for all applicants and will not be based on a sliding scale.

Has the state considered a simplified re-certification process for medically eligible applicants, in order to avoid concerns that an annual application fee coupled with the requirement to reapply annually, may result in very sick people experiencing costly breaks in coverage or losing coverage completely?

The application fee is considered a one-time fee per period of eligibility. We do not anticipate collecting another application fee each year.

We will require that medically eligible enrollees, like other enrollees, regularly re-establish their eligibility with the Department of Human Services, however. If their income has changed, their premium could be affected, and if they have acquired access to insurance, they would be disenrolled from TennCare unless they become eligible for Medicaid.

14. Will enrollment periods differ for medically eligibles who are closer to the poverty threshold than others? Page 10 states: ". . . option of allowing continuous enrollment for those medically eligibles who have incomes no greater than poverty . . ." What about individuals who do not fall near the poverty line?

Medical eligibles who have incomes above poverty can apply for TennCare only during open enrollment periods.

15. Rehabilitation hospital services—For both the Medicaid population (over 21) and the waiver-eligible population, inpatient rehabilitation hospital services will only be covered when determined cost-

effective by the MCO. Please explain what this standard means, how it will be applied or how an MCO will determine cost-effectiveness, and how the state intends to monitor these determinations.

The policy of offering rehabilitation hospital services as a cost-effective alternative is not a new one. Since the beginning of TennCare, we have included in the benefit package "coverage of rehabilitation services when determined cost effective by the MCO." This policy has caused some understandable confusion, since from time to time people have asked if this applied to all rehabilitation services (physical therapy, etc.). In our waiver amendments, we wanted to take the opportunity to clarify that we have always meant only rehabilitation hospital services when we spoke of cost-effective rehabilitation services. Rehabilitation hospital services were not covered for adults under Medicaid.

The state does not have criteria for "cost effectiveness," since we consider this to be an MCO decision. TennCare has chosen to focus on assuring that medically necessary covered services needed to treat enrollees' health conditions are available, rather than on extending recognition to particular provider types. We want to make certain that people requiring medically necessary services get them in an appropriate setting, and in some cases rehabilitation hospitals may be a more cost-effective setting than an acute care hospital. MCOs have the discretion to put together a package of services either inside or outside a rehabilitation hospital that would meet the patient's needs. We believe that allowing this kind of flexibility and focusing on services rather than provider types are critical components of true managed care.

16. Effective date of coverage—The effective date of coverage for an individual determined eligible during an open enrollment period is anticipated to be 60 days after the end of the open enrollment period. How long do the open enrollment periods run?

At this time, we anticipate that the average open enrollment period should run about four weeks. These periods will occur in the spring and in the fall, subject to legislative appropriations and availability of funding under the budget neutrality cap. Those who enroll during the fall period will be eligible effective January 1 of the following year. Those who enroll during the spring period will be eligible effective July 1 of the same year.

17. Immigrant access—Please explain how not-qualified immigrants obtain Medicaid coverage of emergency services.

This process is unchanged since the days of Medicaid prior to TennCare. Hospitals and other providers of emergency services generally work with the Department of Human Services to obtain Medicaid coverage of emergency services for not-qualified immigrants. We did not include this group in our waiver amendment since the processes have not changed and the individuals applying through these processes are not eligible for a full range of Medicaid benefits.

At present, non-qualified immigrants are enrolled in MCOs for provision of emergency services. For ease of administration, we are considering enrolling all not-qualified immigrants in TennCare Select for the period of time they are eligible.